Conversations in Long Term Care
Changes in Food Intake and Nutrition in the Older Adult
Health Care Professional Resource

The focus of care when a person is first admitted to a long term care facility typically is to **optimize nutrition. As malnutrition** has been associated strongly with negative consequences including impaired immune response, impaired muscle and respiratory function, delayed wound healing, and overall reduced functioning promoting adequate nutrition is of benefit. Communication of the presence of malnutrition needs to be done with care, and may not be directly communicated at all, due to the meaning associated with the term "malnutrition". Rates of malnutrition are high in long term care (40 to 60%).

It often is challenging for people to consume enough food to meet needs due to:

- the physiological changes that occur during the lifespan,
- the impact that medical conditions and symptoms have on food consumption

Physiological Changes:
The aging process brings with it a physiological decrease in appetite and a subsequent reduction in food intake which may result in unintentional weight loss. Unintentional weight loss is associated with increased morbidity and mortality. The cause of this reduced intake and weight loss may include:

- A decline in smell and taste with increasing age
- An impairment in the relaxation of gastric distention and a related early satiety
- A slowing of gastric emptying which may prolong the satiety effect of the meal
- Release of cytokines (signaling cells) during aging, which contribute to anorexia and muscle loss.

Impact of medical conditions on food consumption:
Specific diet restrictions may be recommended because of medical conditions such as neurological diseases resulting in dysphagia or organ failure such as renal disease. The need for diet restriction needs to be balanced against the risk of malnutrition. There is evidence that **careful** liberalization of the diet helps support intake.

Social and Emotional Meaning of Food:
On admission, a person may have poor nutrition due to difficulties at home in accessing food (shopping), meal planning and food preparation. Simply as a result of being admitted, intake may improve with three square meals provided daily in a social setting and individualized nutrition assessment. During the earlier stages of admission, it is possible that nutritional status will improve.

It is important to realize that eventually a reduction in intake occurs due to **irreversible physiological changes**, and providing nutrition through any means (orally or via tube feeding) will not result in improvements in status, and may cause discomfort. While this natural process is thought to be an adaptive process that allows death to occur with less suffering (see End of Life Toolkit), it is important to realize that poor intake may cause distress to the caregiver due to the emotional and social meaning of food. Food is used in culturally defined ways, with the meaning of food far exceeding that of simply providing sustenance:

- Eating and drinking are central symbols within most cultures. Food is included in celebrations and is thought of as a tangible expression of love and care.

- Food is a social vehicle; it allows people to establish social linkages, such as by sharing food.
- Food practices are among the cultural habits that humans learn first and are the ones they have the greatest reluctance to change.

While there is a benefit to eating and drinking less as these physiological changes occur, some may make a natural connection between providing food & nourishment and providing care & being nurturing. Even though tube feeding has not been shown to improve quality of life in many situations, tube feeding can provide a sense of hope, and conversely, there may be a sense of giving up or abandonment when tube feeding isn't provided. Careful conversation is needed to address these concerns. (Refer to Adult Enteral Nutrition - Starting a Collaborative Conversation Clinical Practice Guideline http://www.wrha.mb.ca/extranet/eipt/EIPT-034.php)

Points for Practice:

As a basic tenant of person centered care, respect for the individual, considering unique values and personal history, must be considered in determining importance of food and fluid during the course of admission, especially when declining intake occurs. The meaning of food from a cultural perspective may become even more important during this time. It is important that:

- we take our cues from the person and family to determine what is important to them.
- There is recognition that pressuring a person to eat increases anxiety and stress and can worsen symptoms, such as nausea and vomiting. Making mealtimes as relaxing and enjoyable as possible is recommended.
- While, from a logical perspective, it may be understood that food is not important as one approaches end of life, from an emotional perspective, there may be difficulty accepting this. It is important to ensure understanding that a peron is not "starving" and that there are other types of care that can be provided to provide comfort.
- It is ideal to focus on "what one likes" rather than "what is perceived to be nutritionally right".
- At end of life, the person no longer accepts food or drink due to the shutting down of systems. The heart, brain, liver and kidneys (to name a few) are less able to perform their functions. The digestive system also is affected, often to the point where food just cannot be digested. During this natural process, the person is not starving to death as the body no longer needs the same amount of energy. Comfort is key; one way of providing comfort is through regular mouth care. The dietitian can provide a valuable service at this time in informing caregivers of the usual changes that occur and that food and fluid are not of benefit but may contribute to negative effects. (See EOL Toolkit, Nutrition and Swallowing Changes at End of Life resource).

Evidence and Tools to Guide Practice:

Winnipeg Regional Health Authority Tools:

Adult Enteral Nutrition - Starting a Collaborative Conversation Clinical Practice Guideline
http://www.wrha.mb.ca/extranet/eipt/EIPT-034.php

Malnutrition:

Babineau, J., Villalon, L., Laporte, M., & Payette, H. (2008). Outcomes of screening and nutritional intervention among older adults in healthcare facilities. Canadian Journal of Dietetic Practice and Research, 69(2): 91-96.

Canadian Malnutrition Task Force. Canadian Malnutrition Task Force: Overview of Results. Retrieved from: www.rgpeo.com/media/30950/november2011.pdf on October 12, 2015.

Leydon, N. & Dahl, W. (2008). Improving the nutritional status of elderly residents of long-term care homes. Journal of Health Services Research & Policy, 13 (suppl. 1): 25-29.

Thomas, D. R., Ashmen, W., Morley, J. E., Evans, W. J., & the Council for Nutritional Strategies in Long-Term Care (2000). Nutritional management in long-term care: development of a clinical guideline. Journal of Gerontology: Medical Sciences, 55(22), M725-M734.

Milne, AC, Potter, J., Vivanti A., Avenell A. (2009). Protein and energy supplementation in elderly people at risk from malnutrition. Cochrane Database of Systematic Reviews. Issue 2. Art no.: CD003288. DOI: 10.1002/14651858.CD003288.pub3

Liberalization of the Diet:

Academy of Nutrition and Dietetics. Practice Paper of the American Dietetic Association: Individualized Nutrition Approaches for Older Adults in Health Care Communities. JADA, 2010, 110(10): 1554-1563.

Cultural aspects related to food and mealtimes:

Goody, C, Drago, L, 2009, Using cultural competence constructs to understand food practices and provide diabetes care and education, Diabetes spectrum, vol 22(1): 43

Burns, C. Seeing food through older eyes: The cultural implications of dealing with nutritional issues in aged and ageing, Ed. Nutrition & Dietetics 2009; 66: 200–201

Mealtimes in Long Term Care:

Nijs KA, de Graaf C, Siebelink E, Blauw YHk, Vanneste V, Kok FJ, et al. Effect of Family-style meals on energy intake and risk of malnutrition in Dutch nursing home residents; a randomized controlled trial. J Gerontol. A boil Sci Med Sci 2006; 61:935-42.

Nijs KAND, de Graaf D, Kok FJ, van Staveren WA. Effect of family style mealtimes on quality of life, physical performanace, and body weight of nursing home residents; cluster randomized controlled trial. BMJ 2006; 332:1180-4.

Anorexia of Aging and Nutrition at End of Life:

Candy B, Sampson E, Jones L. Enteral tube feeding in older people with advanced dementia: Findings from a Cochrane systematic review International Journal of Palliative Nursing 2009, Vol 15 (8): 396-404.

van der Riet, P., Good, P., Higgins, I., & Sneesby, L. (2008). Palliative care professionals' perceptions of nutrition and hydration at the end of life. International Journal of Palliative Nursing, 14(3), 145-151.

Visvanthan R. Under-Nutrition in Older People: A Serious and Growing Global Problem! Journal of Postgraduate Medicine 2003; 49: 352-360.

Morley JE, Thomas, DR, Wilson, MMG. Cachexia: pathiology and clinical relevance. The American Journal of Clinical Nutrition 2006; 83: 735-743.

Athas BM. Palliative Care and Nutrition Intervention. Journal of Nutrition for the Elderly 2001; 20 (4): 53-60.

Consumer Tools:

Nutrition & Cachexia, Hospice Palliative Care Program, Symptom Guidelines, Fraser Health

Food for Thought, if your loved one isn't eating, the Palliative Pain & symptom Management program, Thunder bay, ON

Symptom Management Pocket Guide: Loss of Appetite, Cancer Care Ontario, June 2012 www.cancercare.on.ca/symptools